with both corneæ yet intact, whose left eye was now, however, already lost, and whose skin, near the outer angle of each eye, was affected with diphtheritic patches, the palpebral conjunctiva of the right eye was quite stiff and smooth—*i. e.*, in that condition which does not yield to cauterization; and the cornea was perforated at the bottom. On eversion of the lids, the iris protruded—vascularized, infiltrated, a fleshy mass. Under chloroform, an incision was made with a Beer's knife through the protruded iris, and scissors were employed for the removal of the prolapse, when the capsule came into view, which was now opened with the cystitome. The eye being already less in size than its fellow, the exit of the lens had to be promoted by pressure with the curette, and, this unavailing, by slight dilatation of the corneal opening with the knife. After the evacuation of the lens, some of the vitreous body was removed three or four times with scissors. Fully the upper half of the cornea was yet preserved; the eye looked rather more promising after the operation; yet scarcely any hope was held out. Von Graefe then applied the compressive bandage, which, in such conditions, is regularly employed in alternation with tepid chamomile fomentations. Death, which in most instances closes the scene, is looked upon as the only consolation in these distressing cases."—*Reminiscences of a Four Months' Stay with Prof. A. Von Graefe*, in *Brit. Med. Journ.*, April 14, 1866.

39. *Treatment of Pannus.*—According to Dr. SAMELSON Dr. Graefe esteems two proceedings for the relief of pannus; viz., peritomy and iridectomy. Inoculation is well-nigh abandoned, owing to its results having been unpropitious in Von Graefe's hands; though he is far from discrediting the more fortunate experience of others, particularly Belgian ophthalmologists, with whom different conditions appear to favour the enterprise. Peritomy is not unfrequently practised; only a small ring of conjunctiva is removed, and the caustic, as originally recommended by Furnari, is dispensed with. The effects obtained are moderate. Of great interest we thought the insistance upon iridectomy, as necessitated in a good many cases of pannus by the coexisting slow iritis, which is very apt to be overlooked, yet, while it lasts, robs of their effectiveness whatever measure may be adopted.—*Ibid.*

40. *Dermoid Tumours.*—These, Dr. SAMELSON states, are not unfrequently seen, at Graefe's clinic, mostly astride on the corneo-scleral frontier, are successfully removed by dissection, which is not generally found necessary to be thorough.—*Ibid.*

41. *Syphilitic Affections of the Eye.*—MM. QUAGLINO and SCARENZIO arrive at the following conclusions from a number of observations.

1. Though there are no characteristic signs of syphilitic retinitis, it may be affirmed that the disease in the majority of cases affects the entire field of the optic papilla, the surrounding portion of the retina, and the yellow spot. The contour of the papilla frequently presents masses of black pigment, giving it an irregular appearance, and apparently due to proliferation of the pigment-cells of the choroid. Syphilitic retinitis frequently terminates in pigmentary degeneration and atrophy of the retina to a greater or smaller extent, in atrophy of the retinal vessels and of the nervous substance of the papilla, and in lesion of the posterior aspect of the retina, characterized by a reflection of a grayish or ashy colour, most apparent in the course of the vessels. In severe cases, the choroid may be attacked, giving rise to the formation of yellowish serous and lymphatic exudation, loss of pigment, and compression of the retina, with atrophy of the columnar layer. In such cases, the pigment-cells of the choroid are infiltrated into the meshes of the atrophied retinal tissue, and constitute the peculiar alteration termed pigmentary retinitis; the pigment may in this way be spread over the whole surface of the retina, and even over the optic papilla. When the amaurosis produced by syphilitic retinitis is secondary to the extension of a morbid process from the iris to the choroid and retina, it is impossible, although the papilla be still free, to examine the fundus of the eye, in consequence of the presence of grayish false membranes, and of the dulness

of the superficial layers of the crystalline lens. Syphilitic retinitis and choroiditis, as well as iritis, are developed most frequently in an advanced stage of the constitutional affection, and belong to the secondary as well as to the tertiary phenomena.

2. In most cases, the functional symptoms of syphilitic retino-choroiditis are the following. *a.* There are asthenopia, trembling and uncertain vision, photophobia, visions of globes of fire or black spots, chromatopsy or pseudo-chromatopsy, and muscæ volitantes. *b.* There is a gradually increasing weakness of the power of vision. *c.* The field of vision becomes progressively limited from the circumference until it is limited to a narrow space. Frequently also obscurity commences in the centre of the field of vision. In either case, sight may remain limited, or may extend little by little. *d.* The hemeralopia which is often observed in cases of degeneration or pigmentary infiltration of the retina in syphilitic subjects, is a phenomenon which appears very late, and appears to be the effect of loss of sensibility in the retina and progressive atrophy of the papilla. *e.* If constitutional syphilis have produced periostitis of the orbit or a swelling implicating the filaments of the fifth pair of nerves, the patient experiences, independently of impaired vision, violent supraorbital neuralgia, with nocturnal exacerbations; exophthalmia may even be produced: there is then a severe almost constant pain in the temporal and frontal regions. The motor nerves alone may be attacked.

3. These affections have generally a very slow, often irregular course.

4. In the early period of syphilitic retinitis, antiphlogistics and resolvents are employed with advantage, especially if symptoms of inflammation be present. When these are absent, the simple fact of impairment of vision in a syphilitic subject indicates the use of a specific treatment—mechanical friction, iodide of potassium, etc. Tonics should be added, if there are threatenings of atrophy of the retina. Under such treatment, patients have almost entirely recovered sight.

5. Cure is no longer possible when atrophy of the retina actually exists. Other nerves than the optic may, when affected, return more readily to their normal state, by reason of their structure being less complicated. If the retina be slightly obscured, but the columnar layer remain intact, there will be only impairment of vision for distant objects.—*British Med. Journ.*, Feb. 10, 1866, from *Gaz. Méd. de Paris*, November 11, 1865.

MIDWIFERY.

42. *Causes of the Position of the Fœtus.*—Prof. von Scanzoni, of Würzburg, sums up a paper on the causes of the frequency of the head-presentation in the human fœtus, with the following conclusions. 1. The frequency of the cranial position of the embryo during pregnancy is not explained by Simpson's theory of reflex movements of the fœtus; nor, as alleged by Dubois, by its instinctive movements; nor by the hypothesis of Carus, according to which the fœtus lives a mere vegetable life within the uterus. 2. The position of the fœtus is dependent on the operation of various circumstances: viz., *a*, the force of gravitation; *b*, the form of the uterine cavity; *c*, the form of the fœtus; *d*, the quantity of amniotic fluid; *e*, the contractions of the uterus during pregnancy and the first stage of labour; and *f*, the active movements of the fœtus. 3. Up to the time when the placenta is developed, the embryo may assume any position, vertical or horizontal, in the cavity. 4. Immediately after the formation of the placenta, the fœtus is suspended at its lower end by a very short umbilical cord to the upper part of the uterus, and the large heavy head hangs downwards. 5. This position may, in favourable circumstances, be maintained during the whole of pregnancy; but much more frequently it undergoes changes into other positions, from which, as a rule, a return is finally made to the head-presentation. 6. The first of the causes influencing the position of the fœtus is the rapid